Frequently Asked Questions about Billing Medicare for Transitional Care Management Services

Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization. This policy is discussed in the CY 2013 Physician Fee Schedule final rule published on November 16, 2012 (77 FR 68978 through 68994). The following are some frequently asked questions that we have received about billing Medicare for transitional care management services.

- **What should practitioners do if claims for appropriately furnished Transitional Care Management (TCM) have been rejected or denied by Medicare?**

  We understand that many practitioners have had difficulty being paid for TCM services, which are new services beginning January 1, 2013. In many cases, claims submitted for TCM services have not been paid due to several common errors in claim submission. We encourage practitioners to verify that all requirements for furnishing the service have been met, and if so, to re-submit any unpaid claims. In particular, the practitioner should ensure that the entire 30-day TCM service was furnished on or after January 1, 2013 (i.e. discharge occurred on or after January 1, 2013), that the service began with a qualified discharge from a facility, and that the date of service on the claim is the final day of the period of TCM services (the 30-day period for the TCM service begins on the day of qualified Medicare discharge and continues for the next 29 calendar days. The reported date of service should be the 30th day). We also have made some adjustments to our claims processing systems to better accommodate the unique billing requirements of this new, 30-day service. We believe that with the adjustments that we have made and extra care with billing on behalf of practitioners, that the problems that have been encountered will be alleviated.

- **What date of service should be used on the claim?**

  The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

- **What place of service should be used on the claim?**

  The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

- **If the codes became effective on Jan. 1 and, in general, cannot be billed until 29 days past discharge, will claims submitted before Jan. 29 with the TCM codes be denied?**

  Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after

January 1, 2013 are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

- **The CPT book describes services by the physician's staff as "and/or licensed clinical staff under his or her direction." Does this mean only RNs and LPNs or may medical assistants also provide some parts of the TCM services?**

  Medicare encourages practitioners to follow CPT guidance in reporting TCM services. Medicare requires that when a practitioner bills Medicare for services and supplies commonly furnished in physician offices, the practitioner must meet the "incident to" requirements described in Chapter 15 Section 60 of the Benefit Policy Manual 100-02.

- **Can the services be provided in an FQHC or RHC?**

  While FQHCs and RHCs are not paid separately by Medicare under the PFS, the face-to-face visit component of TCM services could qualify as a billable visit in an FQHC or RHC. Additionally, physicians or other qualified providers who have a separate fee-for-service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the MPFS.

- **If the patient is readmitted in the 30-day period, can TCM still be reported?**

  Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.

- **Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?**

  Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate evaluation and management (E/M) code.

- **Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30 day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay?**

  Medicare will only pay the first eligible claim submitted during the 30 day period that commences with the day of discharge. Other practitioners may continue to report other

reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

- **Can TCM services be reported under the primary care exception? Can the services be reported with the –GC modifier?**

  TCM services are not on the primary care exception list, so the general teaching physician policy applies as it would for E/M services not on the list. When a physician (or other appropriate billing provider) places the -GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in the Medicare Claims Processing Manual, Chapter 12, sections 100.1 through 100.1.6.

- **Can practitioners under contract to the physician billing for the TCM service furnish the non-face to face component of the TCM?**

  Physician offices should follow "incident to" requirements for Medicare billing. "Incident to" recognizes numerous employment arrangements, including contractual arrangements, when there is direct physician supervision of auxiliary personnel.

  This issue is addressed in greater detail in the Internet-only Benefit Policy Manual, Chapter 15, Section 60 available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html

- **During the 30 day period of TCM, can other medically necessary billable services be reported?**

  Yes, other reasonable and necessary Medicare services may be reported during the 30 day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182.

- **If a patient is discharged on Monday at 4:30, does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?**

  In the scenario described, the practitioner must communicate with the patient by the end of the day on Wednesday, the second business day following the day of discharge.

- **Can TCM services be reported when furnished in the outpatient setting?**

  Yes. CMS has established both a facility and non-facility payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.